APPLICATION FOR REIMBURSEMENT OF MEDICAL EXPENSES

This form should be completed by the principal insured. Please enclose prescriptions(1) and any original medical bills which you have paid. These should show a breakdown of costs. If you requested a prior agreement(2) from us before undergoing treatment, please enclose a copy of our response.

These documents should be returned to:
APRIL International Care France - Service Courrier (mail service) - 1, rue du Mont - CS 80010 - 81700 Blan - FRANCE

(1) Prescription: recommendation in writing from a doctor for treatment, tests and/or medication.
(2) Request for prior agreement: form completed by a qualified medical authority enabling the insured to obtain prior agreement from APRIL International Care for certain medical procedures or treatment.

Your employer
(to be completed if you are insured through your employer)

Name of your employer:
Your employer's policy number:

Principal insured

Surname:	First name:
Client reference number:	Policy number:

Your medical expenses

If you are claiming for maternity costs, please send us proof that you have formally declared the pregnancy.

Patient name *(nom et prénoms)*	**Date of treatment** *(DD/MM/YYYY)*	**Description of treatment received** *(specify if due to an accident)*	**Cost of treatment** *(specify the currency)*

I, the undersigned, Mr/Mrs/Ms....., insured by APRIL International Care, declare on my honour that I have paid for the medical care listed above and that neither I nor the other beneficiaries of the policy have received any reimbursement of these costs from any other insurance provider. I authorise APRIL International Care's Medical Examiner to access information concerning my health. I declare that the information provided above is accurate. Any information which proves to be incorrect, falsified or exaggerated or any fraudulent declaration will incur the liability of the insured and may lead to prosecution. This declaration applies to all persons for whom I am legally responsible and who have the same insurance cover.

At ..... **Date** .....

Signature of the principal insured:

Preferred payment method

If this is your first claim, and if you did not provide us with bank details when you took out the insurance cover, payment will be made by cheque in euros. If you want to receive future payments by other means, please complete the following:

Please make payment by:

❍ cheque

- ❍ euros
- ❍ US dollars *(US residents only). Bank charges will apply unless you are insured under your employer's group policy.*

❍ bank transfer

- ❍ transfer to a bank account in France: enclose bank details
- ❍ transfer to a bank account abroad (bank charges will apply unless you are insured under your employer's group policy)

Your bank details:

Your bank: ....

Address of your bank: ....

Post code: |_|_|_|_|_| Town: ....

Country: ....

IBAN/ABA routing number: |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

BIC/SWIFT: |_|_|_|_|_|_|_|_|_|_|_|

Account number: ....

Currency of your bank account: ....

Account holder: ....

New address for delivery of statements

If you want to change the address to which your statements are sent, please complete the following:

Surname: .... First name: ....

Address: ....

....

Post code: |_|_|_|_|_| Town: ....

Country: ....

Telephone: |_|_|_|_|_|_|_|_|_|_| |_|_| *from outside France* Fax: |_|_|_|_|_|_|_|_|_|_| |_|_| *from outside France*

Email: |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_| @ |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

april International Care

14, rue Gerty Archimède - 75012 Paris - FRANCE

Tel: +33 (0)1 73 02 93 93 - Fax: +33 (0)1 73 02 93 90 - Email: info.expat@april-international.com - **www.april-international.com**